WEST VIRGINIA'S IMPLEMENTATION OF THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996

With the passage of legislation in 1997, West Virginia met the requirements of federal legislation which impacts health insurance coverage for many of its citizens. Under certain circumstances, the federal Health Insurance Portability & Accountability Act of 1996 (HIPAA) and the state law implementing HIPAA:

- Limit exclusions for preexisting medical conditions
- Prohibit discrimination in enrollment against employees and their dependents based on health status
- Guarantee availability of health insurance coverage for individuals and small employers and renewability of health insurance in the individual market, as well as in the small- and large-group markets.

Preexisting Condition Exclusions. A primary purpose of HIPAA is to improve the availability and portability of group health insurance coverage. Portability does not mean that people will carry the same health plan from one job to another. It does mean that people with preexisting conditions will not temporarily lose coverage for those conditions because they changed jobs and had to change health plans. Currently, some employer health plans do not cover preexisting medical conditions. HIPAA limits the time period of these restrictions so that most plans must cover an individual's preexisting condition after 12 months (or 18 months if you're a "late enrollee" who didn't sign up for health insurance at the first opportunity). Under HIPAA, your new employer's plan will be required to give you credit for the length of time that you had continuous health coverage. If, at the time you change jobs, you already have 12 months of continuous health coverage (without a break in coverage of 63 days or more), you will not have to start over with a new 12-month exclusion for any preexisting condition.

Preexisting condition exclusions cannot be applied to pregnancy, regardless of whether the woman had previous coverage. In addition, a preexisting condition exclusion cannot be applied to a newborn, an adopted child under age 18 or a child under 18 placed for adoption as long as the child became covered under the health plan within 30 days of birth, adoption or placement for adoption, and provided the child does not incur a subsequent 63-day or longer break in coverage.

Nondiscrimination Requirements. Group health plans and issuers may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of a plan based on "health status-related factors." These factors are your health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. In other words, you cannot be excluded or dropped from coverage under your health plan just because you have a particular illness.

The nondiscrimination in eligibility requirements should not, however, be construed as requiring a group health plan or group health insurer to provide any benefits other than those provided for under the terms of the plan or coverage. In addition, the plan or issuer may establish limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

Guaranteed Availability and Renewability. In general, an insurer that offers health insurance in the individual, small- or large-group market must renew or continue coverage that is in force at the option of the individual or plan sponsor unless one of the following exceptions applies:

- Failure to pay premiums
- Fraud or intentional misrepresentation of material fact by the policyholder
- Policyholder's failure to comply with a material plan provision relating to contribution or group participation rules
- The health insurer ceases to offer coverage
- In the case of a group network plan, there is no longer any enrollee in the group health plan who lives, resides or works in the service area; or in the case of individual coverage, the individual no longer lives, resides or works in the service area
. In the case of health benefit plans offered only through a bona fide association, an employer ceases to be a member of the association, or the individual's membership in the association ceases.

In general, an insurer that offers coverage in the small-group market (2-50 employees) must:

- Offer any small employer in the State all products that are approved for sale in the small-group market and that the insurer is actively marketing
- Accept any employer that applies for any of these products.

In addition, that insurer:

- Must accept an eligible individual who applies for coverage during the period the individual first becomes eligible to enroll in the group health plan or during a special enrollment period
- May not impose any restrictions on an eligible individual that are inconsistent with HIPAA's nondiscrimination requirements.

Any health insurance issuer offering health insurance coverage in the individual market in this State must accept every eligible individual who wishes to enroll. That is, the issuer may not, with respect to an eligible individual desiring to enroll:

- Decline to offer coverage or deny enrollment
- Impose any preexisting condition exclusion.

An eligible individual is an individual:

- Whose aggregate periods of creditable coverage is 18 or more months as of the date the individual seeking coverage under the plan, and whose most recent prior creditable coverage was under a group health plan, government or church plan
- Who is not eligible for coverage under a group health plan, Medicare, or Medicaid and who does not have any other health insurance coverage
- Whose most recent coverage was not terminated based on nonpayment or fraud
- Who, if given the option to elect COBRA or some other continuation coverage, elected and exhausted the coverage.